# CT DMR HCBS Waivers

## Vendor Documentation, Progress Notes, and Invoicing Requirements



*Attachments*

# 1. Vendor Authorization of Services

- **Individual Budget**
  - **The individual, family, and case manager choose qualified vendors and build an individual budget within the authorized funding range approved by the region's Planning Resource Allocation Team.**

- **Vendor Agreements (Attachment A)**
  - **A Vendor Agreement with the individual or family is required for any service that has a negotiated rate or a rate that is different than the DMR established rate and for any Agency with Choice services. A vendor agreement is not required for waiver services at DMR established rates.**

- **Vendor Authorization to Provide Services (Attachment B)**
  - **A Regional Administrator approves the individual budget if it is within the authorized funding range and sends each vendor that is identified in the budget an authorization with an effective start. The following DMR tittles can authorize services: Regional Director, Assistant Regional Directors, Resource Administrator, Resource Manager II, Quality Assurance Director, Self Determination Director.**
  - **The authorization includes:**
    - **Consumer name**
    - **DMR #**
    - **Region**
    - **Individual Budget End Date**
    - **Effective start date**
    - **Fiscal Intermediary**
    - **Service type**
    - **Unit of service**
    - **Unit rate**
    - **Units per month**
    - **Monthly dollar commitment**
    - **Annualized dollars for each service type**

## 2. Group Day Services: Day Support Option (DSO), Group Supported Employment (GSE), Sheltered Employment (SHE), Staff Modifier

### a. Service Delivery Documentation

- **As Services are provided in Group settings the vendor documents the delivery of services for each date of service. The required fields for the documentation of services are:**
  - **Participant Name**
  - **Procedure Code - Service Type**
  - **Date**
  - **Start Time**
  - **End Time**
  - **Provider Representative Signs for the time period of the service delivery record**
  - **Service Delivery record can be bi weekly or monthly. Maximum is one month.**

### b. Progress Notes: Minimum Standards

- **Daily At least one of the following for each date of service:**
  - **Daily individual or group activity logs.**
  - **Daily communication logs.**
  - **Daily production data**
  - **Daily programmatic data**
  - **Employment data, hours of paid work**
  - **Clinical Data**
- **Quarterly Progress Note**
  - **Time period: From - To**
  - **IP Goal Area**
  - **Objective (s)**
  - **Summary of activities and progress on objectives**
  - **Date and Signature of person preparing the progress note.**

## 3. Individual Services (Supported Living, IS Habilitation, Personal Support, Adult Companion, Supported Employment Individual (SEI), Individual Day Support)

### a. Service Delivery Documentation – Required Data Fields

- **As individual services are provided in the community, the person's own home, or a family home, the vendor documents the delivery of services for each date of service. The required fields for the documentation of services are:**
  - **Participant Name**
  - **Procedure Code - Service Type**
  - **Date**
  - **Start Time**
  - **End Time**
  - **Signature of Person Providing Service for each date of service**
  - **Documentation Record can be bi weekly or monthly. Maximum is one month.**
  - **Signature of individual or family member at the option of the individual or family member.**

### b. Progress Notes – Minimum Standards

- **Daily For each date of service record tasks performed related to the service type and outcome.**
- **Quarterly Progress Note**
  - **Time period: From - To**
  - **IP Goal Area and Objective (s)**
  - **Summary of activities and progress on objectives**
  - **Date and Signature of person preparing the progress note.**

4. **Other Documentation for Day and Residential Services The DOL, the IP, Consultants, Individual and Family, and Medical Professionals will require other documentation depending on the service and the outcome to be achieved. Examples include**
   - **Daily participation logs.**
   - **Communication logs.**
   - **Programmatic data**
   - **Hours of work**
   - **Time Studies**
   - **Interest Inventories**
   - **Clinical Data**

# 5. Consultative Services

## a. Service Delivery Documentation – Required Data Fields

- **As individual services are provided in the community, the person's own home, or a family home, the consultant documents the delivery of services for each date of service. The required fields for the documentation of services are**
  - **Participant Name**
  - **Procedure Code - Service Type**
  - **Date**
  - **Start Time**
  - **End Time**
  - **Signature of Person Providing Service for each date of service**
  - **Documentation Record can be daily, weekly, bi weekly or monthly. Maximum is one month.**

## b. Progress Notes – Minimum Standards

- **Progress note is required for each date of service which includes:**
  - **Date**
  - **Reason for service (meal plan, counseling, follow up, etc)**
  - **Outcome and follow up notes**
  - **Signature of Person Providing Service**

- **Other Documentation for consultative services will be required depending on the outcome to be achieved:**
  - **Program Data Analysis**
  - **Program Intervention Strategies**
  - **Behavior programs, dietary guidelines**
  - **Guidelines for Staff**
  - **Evaluations and recommendations**
  - **Six month and annual reviews**

# 6. Respite Services

## a. Service Delivery Documentation – Required Data Fields

- **As respite services are provided in the community, the person's own home, or a family home, or a vendor residence, the vendor documents the delivery of services for each date of service. The required fields for the documentation of services are:**
  - **Participant Name**
  - **Procedure Code - Service Type**
  - **Date**
  - **Start Time**
  - **End Time**
  - **Signature of Person Providing Service**
  - **Signature of individual or family member at the option of the individual or family member.**

## b. Progress Notes – Minimum Standards

- **For each date of service record tasks and activities.**
- **Other Documentation as required:**
  - **Clinical Data**
  - **Programmatic data**

# 7. Transportation

## a. Service Delivery Documentation – Required Data Fields

- **Participant Name**
- **Procedure Code - Service Type**
- **Date**
- **Miles traveled or Number of Trips**
- **Purpose of Travel**
- **Provider representative signs for the time period of the service delivery record**

# 8. Family Individual Consultation Support (FICS)

## a. Service Delivery Documentation – Required Data Fields

- **As individual services are provided in the community, the person's own home, or a family home, the vendor documents the delivery of services. The required fields for the documentation of services are**
  - **Participant Name**
  - **Procedure Code - Service Type**
  - **Date**
  - **Start Time**
  - **End Time**
  - **Signature of Person Providing Service for each date of service**
  - **Signature of individual or family member at the option of the individual or family member.**

## b. Progress Notes

- **For each date of service record:**
  - **Date**
  - **Purpose of the service**
  - **Tasks performed**
  - **Outcome**
  - **Follow up notes**
  - **Signature of Person Providing Service**
- **Six month and annual review provided to the case manager.**

# 9. Interpreter Services

## a. Service Delivery Documentation – Required Data Fields

- **As individual services are provided in the community, the person's own home, or a family home, the vendor documents the delivery of services. The required fields for the documentation of services are**
  - **Participant Name**
  - **Procedure Code - Service Type**
  - **Date**
  - **Start Time**
  - **End Time**
  - **Purpose of the Service ( IP participation, Medical, ..)**
  - **Signature of Person Providing Service for each date of service**
  - **Signature of individual or family member at the option of the individual or family member**

## 10. Billing Invoice - Required Data Fields

- **The vendor bills through an invoice to the assigned Fiscal Intermediary on a Bi-weekly or monthly basis. The data required for the invoice is listed below:**
  - **Provider Name and Address**
  - **Provider EIN**
  - **Participant Name**
  - **DMR #**
  - **Billing Period**
  - **Procedure code/service type**
  - **Rate**
  - **Date of service**
  - **Number of units**
  - **The basis for payment is a quarter hour. Round direct service time to the nearest 15 minute increment: round 67 minutes to 1 hour, 68 minutes to 1.25 hours, and 50 minutes to .75 hours.**

## 11. Billing Options

- **Vendors can send hard copies by mail or fax**
- **Vendors can send invoices electronically using a file transfer protocol set up for the vendor by the Fiscal Intermediary.**
- **Vendors can use the excel format that DMR provides (Attachment F)**
- **Or Vendors can use their own format with the electronic import specifications in Attachment G.**

## 12. Payment Options

- **Vendors can have payments mailed or made through direct deposit. The Fiscal Intermediary will provide information on setting up payment through direct deposit.**
- **Payments are made within five days of receipt of a valid invoice.**
- **Checks can be made out for each individual billed, or one check for the total of billable services for all people billed to an FI for a billing cycle.**
- **Primary reasons for held or delayed payments are:**
  a. **Invoice does not include all required information**
  b. **Service billed for is not the same service in DMR authorization**
  c. **Wrong Procedure Code for service type**
  d. **Unit rate in invoice is different than rate in DMR authorization**
  e. **Amount of invoice is greater than amount available in the budget**
  f. **The FI does not have an approved budget or budget amendment/change**
  g. **Bill does not breakdown services (service, dates, hours per day)**
  h. **Bill is missing pages**
  i. **Hours are duplicated from previously paid bills**

Attachment A

# Individual/Family Agreement with Vendor

**Name and Address of Individual/Sponsoring Person:**

(First Name) ( Last Name) (Phone)

(Street ) (City) (State) (Zip Code)

**Name of person services will be provided to:**

(First Name) (Last Name)

**Name of Case Manager:**

(First name) (last Name) (Phone Number)

**Effective date of Agreement:**

**Name and Address of Agency:**

(Name) (Address) (City) (State)

**Contact Person:**

**(Name)** **(Phone Number)**

**Fiscal Intermediary:**

**Check appropriate box:**

☐ **Negotiated Rate** ☐ **Agency with Choice**

**Type of support:**

**Hourly Rate of Pay: $**

**Days/Hours of Work:**

| | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|---|---|
| Hours | | | | | | | |

Billing Method: ☐ Invoices sent directly to FI ☐ Invoices sent directly to family

Terms for Discontinuation of Service (can be negotiated up to a maximum of 30 days):

Agency With Choice

Role of the Individual in Selecting & Dismissing staff:

**I agree to provide the services and supports identified in this agreement and to ensure staff, prior to working alone with individual, are provided standard training and specific training identified in the individual plan.**

Agency Representative Signature:_____ Date:_____

Sponsoring Person Signature _____ Date:_____

# Connecticut Department of Mental Retardation
## HCBS Waiver
### Vendor Service Authorization

Consumer Name:_____ DMR #:_____ Fiscal Intermediary:_____

Case Manager/Broker:_____ Phone # _____ Region: _____

_____ is authorized to provide the following
Agency/Vendor name

services to:_____
Consumer Name

| Service: | Unit | Rate / Unit | Units / Month | Monthly Cost | Annualized Cost |
|---|---|---|---|---|---|
| | | | | | |
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The Agency/Vendor shall invoice the applicable Fiscal Intermediary monthly for services provided.
Check the assigned Fiscal Intermediary below:

F. I. Addresses:

☐ Allied Community Resources, Inc
PO Box 1086
Enfield, CT 06082-1086

☐ Public Partnerships, LLC
6 Admirals Way
Chelsea, MA 02150

☐ SUNSET SHORES
720 Barnum Ave. Cut Off
Stratford, CT 06614

Effective Start Date: _____

Authorized by: _____ Title:_____
Print Name

_____ Date:_____
Signature

## Attachment C

## Sample Bi –Weekly Service Delivery Data for Group Day and Respite Programs

| CONSUMER NAME | | | | | | | | | | | DMR # | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Mon Date | Tue Date | Wed Date | Thr Date | Fri Date | Sat Date | Sun Date | Mon Date | Tue Date | Wed Date | Thr Date | Fri Date | Sat Date | Sun Date | Procedures SHE T2022 DSO T2021 GSE T2019 Staff Modifier |
| Procedure Code | | | | | | | | | | | | | | | |
| Time In | | | | | | | | | | | | | | | |
| Time Out | | | | | | | | | | | | | | | |
| **Time In** | | | | | | | | | | | | | | | |
| Time Out | | | | | | | | | | | | | | | |
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| Procedure Code | | | | | | | | | | | | | | | |
| Time In | | | | | | | | | | | | | | | |
| Time Out | | | | | | | | | | | | | | | |
| Time In | | | | | | | | | | | | | | | |
| Time Out | | | | | | | | | | | | | | | |
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| Staff Modifier | | | | | | | | | | | | | | | |
| Time In | | | | | | | | | | | | | | | |
| Time Out | | | | | | | | | | | | | | | |
| Time In | | | | | | | | | | | | | | | |
| Time Out | | | | | | | | | | | | | | | |
| Time In | | | | | | | | | | | | | | | |
| Time Out | | | | | | | | | | | | | | | |
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**Signature of Person Submitting Form** _____ **Date** _____

**Attachment D**

# Sample CT DMR Waiver Bi-Weekly Service Delivery Data for Individual Services

| Participant Name | DMR # |
|---|---|
| | |

| Service Type | IS Habilitation | Supported Living | Personal Support | Adult Companion | Individualized Day Support | Individual SE | |
|---|---|---|---|---|---|---|---|
| Procedure Code | 97535 | T 2003 | T 1019 | S 5135 | T 2019 | T 2019 | |
| | | | | | | | |
| Service Type | Respite Per Hour | Respite Per Diem | Interpreter | FICS | Behavior Support | Counseling | Nutrition |
| Procedure Code | S 5150 | S 5151 | T 1013 | T 2040 | H 2019 | S 9484 | S 9470 |

**The signature of the individual/family is an optional requirement and is at the sole discretion of the individual or family.**

| Procedure Code | Date | Time In | AM PM | Time Out | AM PM | Individual/Family Signature | Staff Signature |
|---|---|---|---|---|---|---|---|
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**Signature of Staff Submitting Service Delivery Data _____ Date _____**

Attachment E

# THE SAMPLE CORPORATION

## QUARTERLY PROGRESS NOTES:

Client:_____ Date:_____

Program Type:_____ Period Covered: _____ to_____

Program Location:_____

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1.) PROGRAM GOALS:

2.) OVERALL PARTICIPATION:

3.) COMMUNITY PRESENCE:

4.) INCIDENT REPORTS:

5.) ADDITIONAL INFORMATION:

GUIDELINES

- ☐ Service Needs Assessment
- ☐ Safety Assessment
- ☐ Level of Support
- ☐ Health and Safety Screening
- ☐ Level of Support Ambulation
- ☐ Mealtime Guidelines
- ☐ Loading and Unloading Van

Signature of Person Completing Report _____ Date_____

# HCBS WAIVER - INDIVIDUALIZED SERVICES

Sample Agency Name
Sample Agency Address
Town, State Zipcode

Sample Agency Phone Number

Date:_____

Consumer Name:_____

Service Type:_____

Procedure Code:_____

**Start Time:_____ End Time:_____**

**IP Goal Area**

**Tasks Performed**

**Comments:**
**(For example, progress, service changes, vacation notices, or staffing changes, etc.)**

_____ _____

**Service Recipient Approval** **Staff Signature**

Attachment E

# THE SAMPLE CORPORATION
# WEEKLY CALENDAR AND NOTES

DATE

Consumer Name:_____ Week:____/____/____ Program Type:_____

| MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |
|---|---|---|---|---|
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| DATE | STAFF | COMMENTS |
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Attachment F

**PUBLIC PARTNERSHIPS, FISCAL INTERMEDIARY SERVICES**
**FOR THE CONNECTICUT DEPARTMENT OF MENTAL RETARDATION**
**AGENCY INVOICE FORM**

FI Name: Public Partnerships | Invoice Service Period Start Date: 3/1/2006 | End Date: 3/31/2006

Agency Name: Vinfen Corporation of CT | Agency Address: 100 Main St, New Haven CT 11111

Hfac_ID: VINF002 | Prepared On (mmm/yy): Mar06

| DMR ID | CLIENT NAME (LAST) | CLIENT NAME (FIRST) | START DATE | END DATE | Service/Commodity Type | Procedure Code | UNIT | TOTAL UNITS | NR | UNIT RATE | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 44444 | Smith | John | 03/03/06 | 03/31/06 | Group Day – Sheltered Work | T2019 | 15 min | 19.00 | | 10.37 | 197.03 |
| 44444 | Smith | John | 03/07/06 | 03/31/06 | Assisted Living (Per Diem) Level 2 | DSS Code | per diem | 21.00 | | 49.43 | 1038.03 |
| 44444 | Smith | John | 03/10/06 | 03/31/06 | Assisted Living (Per Diem) Level 2 | DSS Code | per diem | 16.00 | | 33.15 | 530.40 |
| 44444 | Smith | John | 03/14/06 | 03/31/06 | Personal Support | S5150 | 15 min | 22.00 | | 23.72 | 521.84 |
| 44444 | Smith | John | 03/17/06 | 03/31/06 | Is Habilitation | S5150 | 15 min | 69.00 | | 8.98 | 619.62 |
| 44444 | Smith | John | 03/21/06 | 03/31/06 | Individualized Day | T1019 | 15 min | 36.00 | | 25.53 | 919.08 |
| 44444 | Smith | John | 03/24/06 | 03/31/06 | I Group Day – Sheltered Work | T2019 | 15 min | 18.00 | | 10.37 | 186.66 |
| 44444 | Smith | John | 03/28/06 | 03/31/06 | Assisted Living (Per Diem) Level 4 | DSS Code | per diem | 2.00 | | 68.95 | 137.90 |
| 44444 | Smith | John | 03/31/06 | 03/31/06 | Respite – Group Out of Home (Day) | S5151 | per diem | 2.00 | | 310.46 | 620.92 |
| 55555 | Jackson | Susan | 03/07/06 | 03/31/06 | Personal Support | S5150 | 15 min | 2.00 | | 23.72 | 47.44 |
| 55555 | Jackson | Susan | 03/14/06 | 03/31/06 | Personal Support | S5150 | 15 min | 2.00 | | 23.72 | 47.44 |
| 55555 | Jackson | Susan | 03/21/06 | 03/31/06 | Respite – Group Out of Home (Day) | S5151 | per diem | 10.00 | | 310.46 | 3104.60 |
| 55555 | Jackson | Susan | 03/28/06 | 03/31/06 | Respite – Individual In Home (Hour) | S2015 | mile | 5.00 | | 0.41 | 2.05 |
| 55555 | Jackson | Susan | 03/30/06 | 03/31/06 | Behavior Management | DSS Code | per diem | 6.00 | | 4.24 | 25.44 |
| 55555 | Jackson | Susan | 03/30/06 | 03/31/06 | Respite – Individual In Home (Hour) | TBD | | 4.00 | | 30.65 | 122.60 |
| 55555 | Jackson | Susan | 03/01/06 | 03/31/06 | IS Habilitation | S5150 | 15 min | 1.00 | | 8.98 | 8.98 |
| | | | | | | | | | | | 0.00 |
| | | | | | | | | 237.00 | | **TOTAL:** | 8150.77 |

**I certify that the information contained in this invoice(s) is true and correct and has been prepared in accordance DMR contract terms**

PREPARER'S SIGNATURE & DATE

PREPARER'S NAME & TELEPHONE NUMBER

PROVIDER'S SIGNATURE & DATE

PROVIDER'S NAME & TELEPHONE NUMBER

Attachment G

# Connecticut Department of Mental Retardation
# HCBS Waivers (IFS and Comprehensive)
# Vendor Billing Invoice Form

| Consumer Name: | Vendor Name/Address: |
|---|---|
| | |
| DMR # | |
| | |
| F.I. | |
| | **Vendor EIN#** |
| Billing Month | T-XIX Provider # |

| Date | Service/Commodity Type | Procedure Code | Unit | #Units | Unit Rate | Total |
|---|---|---|---|---|---|---|
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| | | | | | **Sub Total** | |
| | | | | | **Grand Total** | |

Certification : I certify that the services listed above are true , accurate and complete. I further certify that the services are proper charges against the State of Connecticut and that payment has not been received from other sources. I certify that the services were provided in accordance with applicable Medicaid requirements and with other rules and guidelines as defined by the Connecticut Department of Mental Retardation.

Signature Date

Print Name